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Development and Implementation of a psychological trauma informed undergraduate Mental Health Nursing Curriculum.

Introduction

This article will describe the development and implementation of a psychological trauma informed undergraduate mental health nursing curriculum at the University of Stirling. The rationale for doing so will be advanced via a brief exploration of the literature on the concept, incidence and potential significance of trauma for both individual health and collective wellbeing and the significance of this for both professional practice and education. The 'aASKED' model (Young, Taylor and Smith, 2016) that informed the curriculum and its evolution to the (T)AASKED model will then be presented.

Background

There are multiple definitions of 'trauma', but in essence it can be thought of as referring to an experience or series of experiences that may cause intense physical and psychological stress reactions. The term can be used with reference to *"a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual wellbeing"* (Substance Abuse Mental Health Services Administration, 2012:2). There is now widespread awareness that childhood trauma may have broad and long lasting effects that impact upon self-regulation, mood, and behavior (Webb et al., 2017). Significant relationships have been found between childhood trauma and a range of psychological sequelae (Bellis et al., 2015).

Multiple studies exploring the impact of Adverse Childhood Experiences (ACE) have consistently found strong dose relationships between such experiences and the likelihood of developing a series of adult mental and physical health conditions (McEwen, 2015). Individual ACE scores are not in and of themselves predictive of pathology as they represent only one variable in an individual's life, including key relationships, but the effects observed at a group level are significant. The observed effects of adversity seem to be mediated not only via psychological or sociological mechanisms, but through inflammatory and corticosteroid-related stress pathways that may influence and even alter the development of the brain at key periods, resulting in changes whose effects may be persistent (Danese and Baldwin, 2017). The effects of individual experiences of adversity are compounded by systemic and sometimes historical disadvantage linked to poverty, race and economic exclusion that serve to concentrate the negative impacts of ACE more acutely in some communities (Bellis, 2014). Even where the impact of trauma may not present in ways that meet contemporary mental health diagnostic criteria the human costs evident in outcomes around education, employment, criminal justice, wider social wellbeing and inequality have huge implications for social policy (Couper and Mackie, 2016).

Mental health service users who have experienced trauma will most commonly receive care via mainstream, 'generic' mental health services who may routinely fail

to assess for the presence of trauma (Xiao et al., 2016, Read et al. 2018). The impact and sequelae of trauma may be overt but its presence may also be more subtle and nuanced but equally impactful. Growing awareness of this scenario has led to calls that all mental health services and other services which may work with those with mental health must *recognise* the presence of trauma in those who use (and provide its services) *realise* the significance of the issues associated with it, *respond* by becoming 'trauma informed', reduce the risk of approaches that may *re-traumatise* and promote collaborative person-centred approaches (Substance Abuse Mental Health Services Administration, 2015,). Scotland has been at the forefront of such initiatives with the launch of a national training framework for the NHS workforce (NHS Education for Scotland (2017).

Becoming a trauma informed mental health service requires that services explicitly reflect on their values, care models, narratives, policies, practices, roles and relationships and embark on a potentially deep change programme in order to deliver a safe, supportive and therapeutic environment for staff and service users that incorporates an awareness of the diverse impact of trauma on individuals, families and communities (Wilson et al., 2017). Such efforts depending on the resource and its remit may include promoting access to or directly delivering evidence based specific treatments for trauma.

Facilitating such change requires a mental health nursing workforce who can deliver the profound changes in culture and practice that are required to realise it. (Wheeler 2018). Such a workforce must champion not only the explicit recognition of trauma in those accessing mental health services but promote awareness of the prevalence and effects of trauma exposure and the best methods for supporting children and families exposed to trauma in schools, social services and the general hospitals where the impacts of trauma on physical health need to be recognised (Grant and Lappin, 2017). Working within a trauma informed model of care is more than a preference – it is an ethical imperative. Nurses must therefore be inspired to radically alter the landscape of care provision. A number of initiatives have sought to address this objective in the existing workforce where enhancing understanding, changing attitudes and developing related skills in assessment and treatment are variously required (Palfrey et al., 2018).

Higher Educational Institutions' (HEIs) nurse education programmes must address the dual goals of providing flexible relevant training whilst also ensuring the needs of local communities are met (Parker and McMillan, 2007). Flexibility is key; as programmes of nurse education must keep pace with the continual change in nursing practice (Kermansaravi, Navidian and Yaghoubinia, 2014) and within society (Martin, 2013). Nurses of the present and future need to be skilled to meet the changes in population demographics. Changes that have resulted in the need to recognise trauma as a public health issue that affects not just the individual but also their relationships, community and wider society (Magruder, McLaughlin and Borbon, 2017). As Sines, eloquently, states, academics must '*prepare the next generation of nurses who are capable and confident to provide high quality care for all and to ensure that our nurses are innovative, dynamic, capable and proficient in all that they do*' (Sines, 2013:15).

The key driving principle behind trauma informed approaches is that traditional models whose primary aim is to find 'what is wrong with you' in order to fit the person into a diagnostic category and treat the immediate symptoms may be actively harmful to those who have experienced trauma (Wilson et al., 2017). Trauma Informed Approaches seek to replace this with a fundamentally different 'lens'. This asks 'what has happened' to the person and how has that affected them and requires the practitioner to mutually create a safe relational space in which a shared understanding can begin to underpin recovery (Bloom, 2012). The approach is strength based and therefore complements existing perspectives including recovery

Development of new curriculum

As of 2012 the undergraduate mental health nursing programme at Stirling reflected a growing awareness of trauma involving a series of lectures, workshops and seminars but these were standalone and diagnostically driven e.g. focused on PTSD rather than part of any integrated initiative. Reflection over time based on dissatisfaction with this approach suggested that truly embracing the potential significance of trauma and its full potential in delivering the paradigm shift required in mental health appeared to require a professional curriculum designed from the ground up to incorporate trauma as a core theme (Carello and Butler 2012). This led to the realisation that an entirely new curriculum was required.

In order to become a registered nurse in the UK students must successfully complete an education programme approved by the NMC in one of the four fields of nursing practice – including mental health. From 2013 onwards all pre-registration nursing education programmes across the UK have been required to be at degree level. All universities must demonstrate their adherence to standards set by the NMC and typically must meet defined European standards (WHO, 2009) which note the expected hours of theory and clinical practice student nurses must complete during their training. This duality of pre-registration nurse training – students must engage with and successfully demonstrated theory and knowledge as well as in-vivo practical skills – means that approved HEIs must deliver nursing programmes that address not just the academic learning of students but also how this is successfully applied in a 'real-world nurse – patient relational context'. Universities do, however, retain substantial autonomy in how they structure their pre-registration curriculum, and how they teach and assess their programmes. This leaves scope for curriculum innovations such as this project.

The aims of the new curriculum implemented from 2014 onwards (see Box 1) were developed both to guide the development exercise and to provide a basis for its evaluation. The US Substance Abuse and Mental Health Services Administration (SAMHSA) (2012) identified key principles, and previous published work in other disciplines introducing trauma informed curricula, provided the basic foundation from which the new curriculum was developed. SAMHSA's six key principles of trauma informed care i.e. Safety; Trustworthiness and Transparency; Peer support; Collaboration and Mutuality; Empowerment, Voice and Choice; Cultural, historical and gender issues) help place the person at the centre of their care experience, and seeks to promote a culture based on beliefs about relationships, resilience, recovery and healing from trauma.

The development was also informed by the broader literature including seminal work by Harris and Fallot (2001), Fallot and Harris,(2002, 2009) Courtois and Gold (2009), as well as wider collaboration with students, academic, clinical colleagues, third sector partners, and individuals with lived experience. As a 'live' development since implementation the curriculum has been refined and influenced through student engagement with their learning and their experiences in clinical placement and interaction with clinical colleagues and service users and carers.

From the 'aASKED' model to the (T)AASKED model

Realising the incorporation of trauma as an organising principle required systemic reflection of how best to prepare undergraduate students. This led to the development of the original 'aASKED' model (Young, Taylor and Smith, 2016) into the (T)AASKED model. The acronym chosen reflects the challenge of the 'what, when and how' of curriculum design based on incremental knowledge and skill acquisition moving from Awareness, through Assessment, Skills, Knowledge, Education and Delivery with trauma as the core (Young, Taylor and Smith, 2016) (see Figure 2).

Awareness was driven via the classic 'What', 'So What', 'Now What' framework: (Borton,1970) further developed by Driscoll (2002).

- *What* is trauma, attachment and adverse childhood experiences? Trauma was taught as existing across a spectrum that encompassed individual relational, environmental and historical dimensions and not solely a series of diagnostic categories.
- *So What?* - Why does it matter that we understand about trauma, attachment and adverse childhood experiences and how these are presently being responded to or not in current services. The trauma lens reframes symptoms, however dysfunctional or distressing, as originating as adaptations to trauma and therefore as coping strategies.
- *Now What?* – What is my role? What do we do with that knowledge? What can we do? How do we work in a trauma informed and trauma responsive way? What are my self-care needs and how do I practice trauma stewardship (Lipsky and Burk, 2009), and how do I maintain safety and manage boundaries (Pope and Vasquez, 2005)?

Central to an approach that foregrounds 'what happened to you' is the **Assessment** of trauma. Assessment seeks to identify core relationships and events in the patient's life. It also examines their potential psychological sequelae which can lead to a trauma informed formulation and trauma informed treatment planning. Students at completion of their programme are competent to conduct a robust mental health assessment, including routine inquiry asking about early childhood and traumatic experience. This then forms their clinical formulation based on Johnstone & Dallos' (2013) 'five Ps'; presenting, predisposing, precipitating, perpetuating, and protective factors. This is then shared with their clinical colleagues and informs team care-planning (Johnstone et al., 2015).

To enhance **Skills** Judith Herman's triphasic model was used (Herman, 2008; Herman, 2010). The overall aim is to develop practitioners' confidence, and their competence to have conversations regarding trauma, whilst being sensitive when asking people to speak about their lived experiences. Practical skills development sessions focused mostly but not exclusively around Hermans phase 1 Safety and Stabilisation included recognising dissociation and the delivery of psychoeducation. A range of different exercises were used to do this, including; Group work, Workshops, Role Play, Presentations, Simulation and Problem Based Learning activities. An explicit focus on skills was required in order that their structured development could be planned and resourced (see Box 2).

Knowledge of key concepts were taught. Examples of these included; window of tolerance, neurobiology of trauma, the impact of toxic stress, austerity/ poverty and the implications for public health and social policy. Attachment theory was taught with specific reference to trauma incorporating both the significance of secure attachments as a buffer against trauma and their significance to trauma but also the damage caused when trauma was perpetrated by someone whose role should have been protective. A key message foregrounding much of the momentum within this key area was 'Do No Harm'; an advanced understanding of harm done in the person's past. In order to prevent iatrogenic trauma, students needed to understand the general importance of doing 'no harm' in avoiding re-traumatisation. However, they also needed to 'know harm' in terms of the specifics of the individual's experience in order to understand how harm could result as a consequence of exposure, and re-exposure, to trauma, as well as the individual's strengths and coping strategies (Herman, 1998).

It was understood from the beginning of the curriculum development exercise that **Education** would incorporate multiple strands. Education involved direct contact and engagement by academic and teaching staff with our Mental Health students, but education was also provided by students to clinical staff, patients and carers. As the model was implemented the metaphor of students as 'trauma bees' emerging from the hive (Young, 2016) and going out to pollinate practice settings and local communities, fostering awareness of the need for an alternative trauma informed frame and challenging language and power imbalances, was formed. Cross pollination underpinned a dynamic process in which information regarding issues in contemporary practice was continually fed-back and informed the evolution of the curriculum.

Lastly, a classic blended learning model was used to **Deliver** the curriculum (See Figure 1). Trauma was woven into and across the undergraduate programme including through shared classes with adult students. Co-production with students resulted in a series of conference presentations (Young, 2016) and the 'Trauma Bee's' movie, a film produced that powerfully describing students experiences (Young, 2017). <https://www.youtube.com/watch?v=fhMgzKjRvxs>

Highlighting a key challenge to implementation

As Carello and Butler (2014) note, teaching trauma is not the same as trauma informed teaching; neither is it the same as implementing a trauma informed curriculum. Amongst the many transformations required is the need to explicitly

recognise that trauma impacts upon not only the lives of those who use our services but those who provide it. Potential mental health nursing students may have their own trauma histories and symptoms which may present when under stress. Assessing for the presence of trauma potentially involves exposure to the traumatic events in others' lives, with the potential for vicarious trauma and secondary traumatic stress to develop (Lipsky and Burke, 2009). Addressing self-care and developing resiliency skills was an important aspect the programme. Self-reflection was taught and consistently prompted, peer supports established and touch-points with academic leads established to constantly review support arrangements. Embracing a relational approach in which emotional regulation is fostered requires access to regular skilled supervision to manage the emotions and processes involved. Ensuring that reflective supervision by practitioners who understand the concept of trauma remains a significant challenge.

Conclusion

Trauma informed approaches see symptoms however dysfunctional or distressing as having their origins as adaptations to trauma and therefore as coping strategies. A trauma informed mental health curriculum is ultimately one in which all parties involved explicitly recognise and overtly respond to the impact of trauma on the wellbeing of children, adults, families, organisations, communities and society. It embeds awareness of trauma and an understanding of the implications for facilitating recovery and promoting resilience throughout the programme; where it functions as one of the core pillars informed by an explicit value base that incorporates partnership working and commitments to co-creation and delivery.

The programme at Stirling is currently being revised to enable students to acquire the competencies outlined in the NHS Education for Scotland (2017) Psychological Trauma Framework where the exit point is 'Trauma Informed' or 'Trauma Skilled'. Subsequent revisions will map the programme against the new, recently published, Nursing and Midwifery Council (2018) NMC standards for nurse education. Of note, given the focus of the development and the literature that informed it regarding the significance of trauma as a public health issue, is that these standards make no explicit reference to trauma.

The purpose of this curriculum innovation was to provide a paradigm shift in student nurse education. It is a core part of the ethos that this was not a project but a process. The ultimate aim is that, as well as producing registrants in the nursing field, we are also equipping our future mental health nursing workforce with the skills and knowledge to work within a trauma informed framework, promote radical changes in culture and practice, and fundamentally improve the experience of people who use mental health services to not only be safe but, crucially, feel safe, validated and protected from harm. Facilitating such ambitious change requires vision, leadership, resilience and the ability to navigate a series of potential hazards to innovation both locally and nationally. The curriculum delivered represents where mental health nursing education must be if it is to continue to meet the needs of those who use its services in the future.

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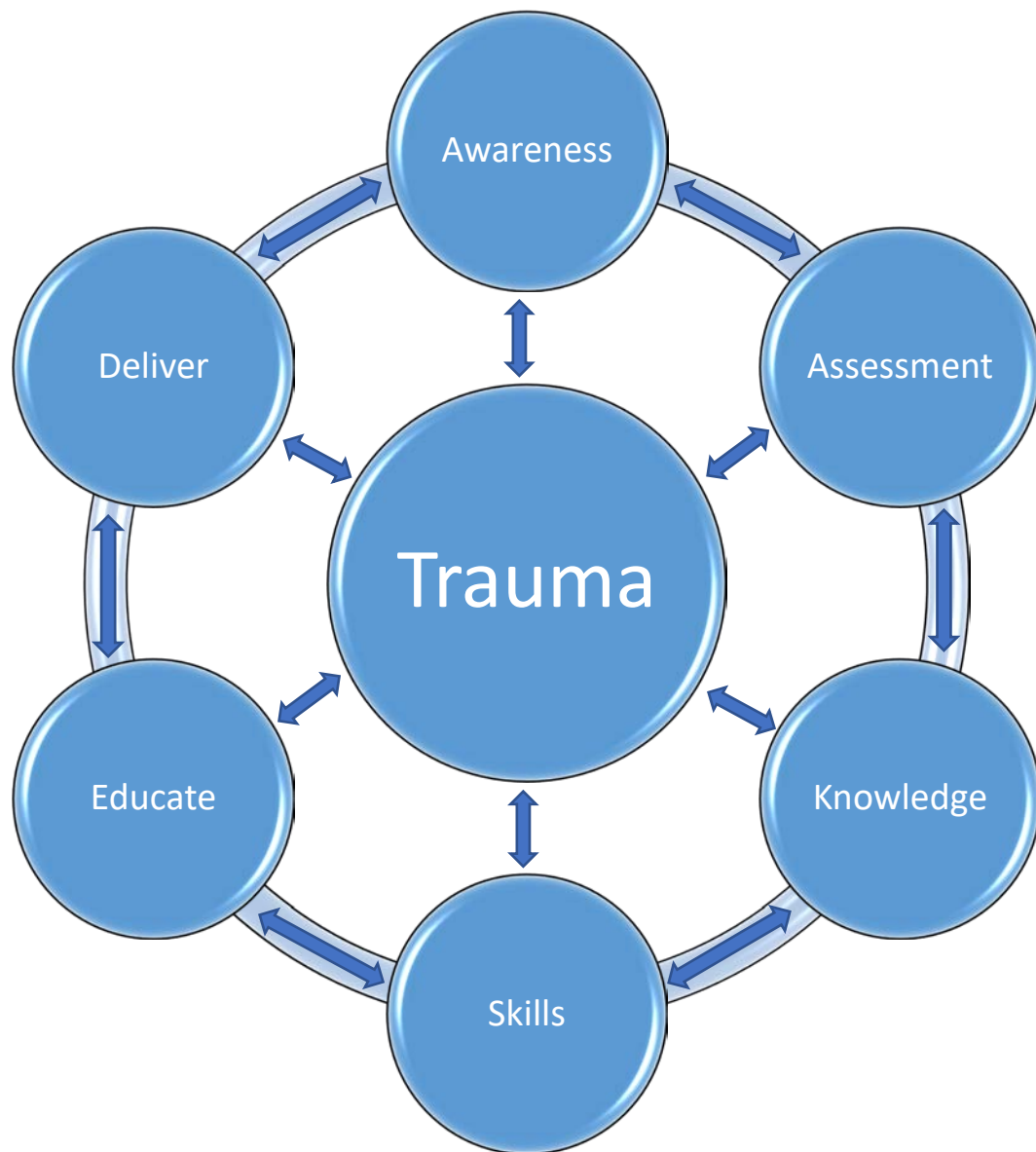
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Box 1. Aims of new curriculum
To enable students to develop, extend and deepen their knowledge of theory and practice in the field of psychological trauma, leading to a paradigm shift towards delivering trauma informed care by :-
Critical appraisal of the concepts of adversity & psychological trauma and their impact across the lifespan
Critical evaluation of its impact on physical and psychological health and wellbeing.
Developing and demonstrating the fundamental skills/practice used in the assessment process and identify appropriate treatment interventions available
Demonstrating an enhanced psychological literacy when developing and interpreting clinical formulation.
Identifying and analysing factors supporting, or barriers to, intervention and change
Realising, Recognising, and Responding to the psychological needs of individuals who have experienced adversity and trauma.
Informing and developing Trauma informed approaches in order to resist and prevent re-traumatisation
Critical understanding of protective and resiliency factors which may mitigate the impact of trauma.

Figure 1: Blending Learning Model: Delivery of Trauma informed Curriculum



Figure 2. The 'TAASKED' model



Box 2. Skills for Practice

- Relational skills
- Routine enquiry
- Engagement
- Safety
- Stabilisation
- Psychoeducation
- Grounding
- Containment
- Distress tolerance
- Collaboration
- Empowerment
- Strengths and Assets based approaches
- Resilience
- Self-care